3166-001	$200.00
3166-001	50.00
3166-001	150.00
3166-006	10.00

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS

BOARD FOR PROFESSIONAL COUNSELORS, MARITAL & FAMILY THERAPISTS, AND CLINICAL PASTORAL THERAPISTS

227 French Landing, Suite 300
Heritage Place Metro Center
NASHVILLE, TENNESSEE 37243
www.tennessee.gov
(800) 778-4123, ext. 25138
(615) 532-3202, ext. 25138

APPLICATION FOR LICENSE AS A PROFESSIONAL COUNSELOR

_____ **LPC**

_____ **LPC/MHSP (MHCE)***

_____ **Temporary**

_____ **Reciprocity**

_____ **Upgrade from CPC to LPC**

- Please review Rule 0450-1-.04 Qualification for Licensure
- Enclose a certified copy of your birth certificate
- Enclose a passport photo taken within the last 12 months
- Transcripts must be mailed from your educational institution
- NBCC scores must be mailed from National Board Office
- Enclose or have mailed 2 letters of recommendation (must be original, no copies will be accepted)
- Submit $210.00 non-refundable (if applying for temporary licensure please remit $360.00)
- **Please submit the Mandatory Practitioner Profile with your application**

***Please note – LPC-MHSP applicant will be required to take the MHCE given by NBCC**

NAME _____
First **Middle and/or Maiden** **Last**

DATE OF BIRTH _____ **SOCIAL SECURITY #** _____

CURRENT HOME MAILING ADDRESS:

_____
_____
_____

CURRENT PRACTICE ADDRESS:

_____
_____
_____

HOME PHONE # _____ **WORK PHONE #** _____

List all states where you currently have or have ever had a Professional Counselor license.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

COURSE WORK SUMMARY

All graduate courses, titles, and numbers listed on this page must also appear on the transcript(s) sent directly from your college or university to the Board's Administrative Office. If a course is taken in more than one (1) area, list the credit hours in only one (1) category.

COURSE CATEGORIES (Core Area)	*CREDIT HOURS	INSTITUTION
THEORIES OF HUMAN BEHAVIOR, LEARNING AND PERSONALITY		
ABNORMAL BEHAVIOR AND PSYCHOPATHOLOGY		
THEORIES OF COUNSELING AND PSYCHOTHERAPY		
EVALUATION AND APPRAISAL PROCEDURES		
GROUP DYNAMICS, THEORIES AND TECHNIQUES		
COUNSELING TECHNIQUES		
ETHICS		
RESEARCH		
USE OF THE DSM		
TREATMENT AND TREATMENT PLANNING		

*Convert all quarter credit hours to semester credit hours: # of quarter hours x .67 = # of semester hours

COURSE WORK SUMMARY, CONTINUED

If the course work listed on page 2 of this application is less than the sixty (60) hours required by T.C.A. §63-22-104, list additional courses below.

ADDITIONAL COURSE S	*CREDIT HOURS	INSTITUTION

*Count all quarter credit hours to semester hours: # of quarter hours x .67 = # of semester hours

CLINICAL PRACTICUM/INTERNSHIP

LIST THE LOCATION AND DATES OF SUPERVISED PRACTICUM(S)/INTERNSHIP IN COUNSELING, WHICH INCLUDES A MINIMUM OF FIVE HUNDRED (500) CLOCK HOURS OF TRAINING. AT LEAST THREE HUNDRED (300) HOURS MUST BE COMPLETED IN A MENTAL HEALTH OR COMMUNITY AGENCY SETTING.

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to questions in this part are in the affirmative, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice professional counseling"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate diagnosis or evaluation, exercise reasoned judgment, and to learn, and keep abreast of professional counseling developments; and

   b. The ability to communicate those judgments and information to clients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   c. The physical capability to perform required tasks and procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

3. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g., heroin, or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice professional counseling with reasonable skill and safety?	_____	_____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	_____	_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	_____	_____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

QUESTIONS:	**YES**	**NO**
2. Do you currently use chemical substances?	_____	_____
a. If yes, do they in any way impair or limit your ability to practice professional counseling with reasonable skill and safety?	_____	_____
3. Are you currently engaged in the illegal use of controlled substances?	_____	_____
a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____

COMPETENCY INFORMATION, CONTINUED

QUESTIONS:		YES	NO
5.	If you have ever held or applied for a license or certificate to practice professional counseling in any state, country, or province, has it or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6.	If you have ever held staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, or otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7.	Have you ever applied for and been denied a state or federal controlled substance certificate?	_____	_____
a.	If you have possessed such a certificate has it ever been revoked, suspended, restricted, otherwise disciplined, or voluntarily under threat of investigation or disciplinary action?	_____	_____
8.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	_____	_____
9.	Have you ever been rejected or censured by a professional association?	_____	_____
10.	In relation to the performance of your professional services in any profession:		
a.	Have you ever had a final judgment rendered against you;	_____	_____
b.	Have you ever had settlement of any legal action rendered against you; or	_____	_____
c.	Are there any legal actions pending against you or to which you are a party?	_____	_____
11.	If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____
(Applicant's Name) ***(City)*** ***(State)***

being duly sworn and identified as the person referred to in this application, and signed photos attests to the truth of each statement made in said application. I further swear that I have read and understand the statute and the Rules and Regulations, which were enclosed in the application packet, and agree to abide by them in the practice of professional counseling in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice professional counseling.

AUTHORIZE release, use of disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

AUTHORIZE the board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations that provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me this _____ day of _____, _____.

_____ Affix Seal Here
NOTARY PUBLIC

My Commission expires _____

REQUEST FOR TEMPORARY LICENSURE
AS A PROFESSIONAL COUNSELOR WITH
MENTAL HEALTH SERVICE PROVIDER DESIGNATION

Applicant: If you desire a temporary license, have your supervisor complete this page, and add $150 to the fee requested in instruction #2 on the first page of this application. Do not send this page separately; a request for temporary license must be returned with entire application.

Name of Applicant _____
(please print)

I, the undersigned, hereby accept responsibility for direct supervision of the above named applicant.

_____
Name of Supervisor

_____
License Number of Supervisor Date of initial license

Title of Supervisor's License:_____
(i.e., M.D., D.O., L.P.C./M.H.S.P., L.M.F.T., L.C.S.W., Lic. Psychologist)
If license is M.D. or D.O., are you certified by the American Board of Psychiatry and Neurology? ___ Yes ___ No

Name, Address & Telephone # of Supervisor's Facility _____

Telephone # of Supervisor: _____

_____
Signature of Supervisor

Subscribed and sworn to me this _____ day of_____, _____.

_____
Notary Public

My commission expires: _____

(SEAL)

For Office Use Only
Temporary License

Number _____

Issued _____

Expires _____

Extended _____

VERIFICATION OF SUPERVISED POST-MASTERS EXPERIENCE

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS BELOW.

If the applicant is requesting Mental Health Service Provider designation, then on your letterhead stationery please describe the nature of the applicant's client contact and indicate the Mental Health Services which the applicant delivered during the supervised experience. Type or print legibly. The experience should have included significant opportunity to appraise and assess, diagnose psychopathology, formulate treatment plans, and execute treatment using the **DSM** for mental disorders.

TO BE COMPLETED BY THE APPLICANT'S SUPERVISOR

NAME OF APPLICANT: _____

NAME OF SUPERVISOR: _____

TITLE OF SUPERVISOR: _____

LICENSE NUMBER OF SUPERVISOR NAMED ABOVE: _____

TITLE OF LICENSE (i.e. M.D., D.O., L.P.C./M.H.S.P., L.M.F.T., L.C.S.W., Lic. Psychologist/H.S.P.) _____
If license is M.D. or D.O., are you certified by the American Board of Psychiatry and Neurology? ____ Yes ____ No

DATE OF INITIAL LICENSE: _____

EXPIRATION DATE OF LICENSE: _____

IS YOUR LICENSE IN GOOD STANDING? _____

HAVE YOU EVER HAD ANY DISCIPLINARY ACTION TAKEN AGAINST YOU OR YOUR LICENSE? ____ Yes ____ No

IF YES, PLEASE EXPLAIN: _____

_____

I HEREBY CERTIFY THAT I SUPERVISED: _____
THIS SUPERVISION INCLUDED: (Name of Applicant)

_____ HRS. INDIVIDUAL SUPERVISION DATES OF SUPERVISION:

_____ HRS. GROUP SUPERVISION FROM _____ TO _____

_____ HRS OF CLINICAL EXPERIENCE UNDER SUPERVISION

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT.

_____ _____
SUPERVISOR'S SIGNATURE DATE

SWORN TO BEFORE ME THIS _____ DAY OF _____, _____.

_____
NOTARY PUBLIC

MY COMMISSION EXPIRES _____ AFFIX SEAL HERE

SEND TO: Board for PC/MFT/CPT
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

THIS PAGE MAY BE DUPLICATED IF NEEDED.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
BOARD FOR PROFESSIONAL COUNSELORS, MARITAL & FAMILY THERAPISTS,
& CLINICAL PASTORAL THERAPISTS
227 French Landing, Suite 300
Heritage Place Metro Center
NASHVILLE, TENNESSEE 37243
www.tennessee.gov
Toll Free (800) 778-4123, ext. 25138
Local (615) 532-3202, ext. 25138

CLEARANCE FROM OTHER STATE PROFESSIONAL COUNSELING LICENSING BOARDS

Please complete the top portion and mail this form to the regulatory board in each state where you hold or have held a license to practice as a Professional Counselor. (If additional forms are required, this form may be duplicated.)

NOTE: Some states require a fee for providing clearance information. In order to expedite your application, you may wish to contact the applicable state or states.

I was granted _____ on _____ by the State of _____
Lic. # Date

The Tennessee Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists requests that I submit evidence that my license in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board for Professional Counselors, Marital & Family Therapists, & Clinical Pastoral Therapists.

Date: _____ Signature: _____

SSN#: _____ Printed Name: _____

THIS PORTION IS TO BE COMPLETED BY STATE LICENSING BOARD

License Number: _____ Date Issued: _____

Basis of Issuance: _____ Examination: _____ National _____ State _____ Other
_____ Endorsement/Reciprocity
_____ Other

License currently registered: _____ Yes _____ No

Derogatory Information on File: _____ Yes _____ No
If "yes", please attach explanation.

_____ _____ _____
Authorized Signature Title Date

JK/G4019288/PC

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY

PRACTITIONER

PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWORD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health**.**

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider</u> to:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records.</u>**

✓CHECKLIST

Before you mail your questionnaire:

- ☐ Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

- ☐ Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

- ☐ Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER: _____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(_____)_____**(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License #**_____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License#**_____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date:_____
(Signature of Provider)

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